disorders are in excess of those usually associated with Amphetamine Intoxication or Amphetamine Withdrawal and are severe enough to warrant independent clinical attention.

292.9 Amphetamine-Related Disorder Not Otherwise Specified

The Amphetamine-Related Disorder Not Otherwise Specified category is for disorders associated with the use of amphetamine (or a related substance) that are not classifiable as Amphetamine Dependence, Amphetamine Abuse, Amphetamine Intoxication, Amphetamine Withdrawal, Amphetamine Intoxication Delirium, Amphetamine-Induced Psychotic Disorder, Amphetamine-Induced Mood Disorder, Amphetamine-Induced Anxiety Disorder, Amphetamine-Induced Sexual Dysfunction, or Amphetamine-Induced Sleep Disorder.

Caffeine-Related Disorders

Caffeine can be consumed from a number of different sources, including coffee (brewed = 100–140 mg/8 oz, instant = 65–100 mg/8 oz), tea (40–100 mg/8 oz), caffeinated soda (45 mg/12 oz), over-the-counter analgesics and cold remedies (25–50 mg/tablet), antidrowsiness pills (100–200 mg/tablet), and weight-loss aids (75–200 mg/tablet). Chocolate and cocoa have much lower levels of caffeine (e.g., 5 mg/chocolate bar). The consumption of caffeine is ubiquitous in much of the United States, with an average caffeine intake of approximately 200 mg/day, and up to 30% of Americans consuming 500 mg or more per day. Some individuals who drink large amounts of coffee display some aspects of dependence on caffeine and exhibit tolerance and perhaps withdrawal. However, the data are insufficient at this time to determine whether these symptoms are associated with clinically significant impairment that meets the criteria for Substance Dependence or Substance Abuse. In contrast, there is evidence that Caffeine Intoxication can be clinically significant, and specific text and criteria are provided below. Recent evidence also suggests the possible clinical relevance of caffeine withdrawal; a set of research criteria is included on p. 765. The Caffeine-Induced Disorders (other than Caffeine Intoxication) are described in the sections of the manual with disorders with which they share phenomenology (e.g., Caffeine-Induced Anxiety Disorder is included in the "Anxiety Disorders" section). Listed below are the Caffeine-Induced Disorders.

Caffeine-Induced Disorders

305.90 **Caffeine Intoxication** (see p. 232)
292.89 **Caffeine-Induced Anxiety Disorder** (see p. 479)
Specify if: With Onset During Intoxication
292.89 **Caffeine-Induced Sleep Disorder** (see p. 655)
Specify if: With Onset During Intoxication
292.9 **Caffeine-Related Disorder Not Otherwise Specified** (see p. 234)

EXHIBIT A

Caffeine-Induced Disorders

305.90 Caffeine Intoxication

Refer, in addition, to the text and criteria for Substance Intoxication (see p. 199). The essential feature of Caffeine Intoxication is recent consumption of caffeine and five or more symptoms that develop during, or shortly after, caffeine use (Criteria A and B). Symptoms that can appear following the ingestion of as little as 100 mg of caffeine per day include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, and gastrointestinal complaints. Symptoms that generally appear at levels of more than 1 g/day include muscle twitching, rambling flow of thoughts and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. Caffeine Intoxication may not occur despite high caffeine intake because of the development of tolerance. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be due to a general medical condition and are not better accounted for by another mental disorder (e.g., an Anxiety Disorder) (Criterion D).

Diagnostic criteria for 305.90 Caffeine Intoxication

A. Recent consumption of caffeine, usually in excess of 250 mg (e.g., more than 2–3 cups of brewed coffee).

B. Five (or more) of the following signs, developing during, or shortly after, caffeine use:

(1) restlessness
(2) nervousness
(3) excitement
(4) insomnia
(5) flushed face
(6) diuresis
(7) gastrointestinal disturbance
(8) muscle twitching
(9) rambling flow of thought and speech
(10) tachycardia or cardiac arrhythmia
(11) periods of inexhaustibility
(12) psychomotor agitation

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (e.g., an Anxiety Disorder).

Other Caffeine-Induced Disorders

The following Caffeine-Induced Disorders are described in other sections of the manual with disorders with which they share phenomenology: **Caffeine-Induced Anxiety Disorder** (p. 479) and **Caffeine-Induced Sleep Disorder** (p. 655). These disorders are diagnosed instead of Caffeine Intoxication only when the symptoms are in excess of those usually associated with Caffeine Intoxication and when the symptoms are sufficiently severe to warrant independent clinical attention.

Additional Information on Caffeine-Related Disorders

Associated Features and Disorders

Mild sensory disturbances (e.g., ringing in the ears and flashes of light) have been reported at higher doses. Although large doses of caffeine can increase heart rate, smaller doses can slow the pulse. Whether excess caffeine intake can cause headaches is unclear. On physical examination, agitation, restlessness, sweating, tachycardia, flushed face, and increased bowel motility may be seen. Typical patterns of caffeine intake have not been consistently associated with other medical problems. However, heavy use is associated with the development or exacerbation of anxiety and somatic symptoms such as cardiac arrhythmias and gastrointestinal pain or diarrhea. With acute doses exceeding 10 g of caffeine, grand mal seizures and respiratory failure may result in death. Excessive caffeine use is associated with Mood, Eating, Psychotic, Sleep, and Substance-Related Disorders, whereas individuals with Anxiety Disorders are likely to avoid this substance.

Specific Culture, Age, and Gender Features

Caffeine use and the sources from which caffeine is consumed vary widely across cultures. The average caffeine intake in most of the developing world is less than 50 mg/day, compared to as much as 400 mg/day or more in Sweden, the United Kingdom, and other European nations. Caffeine consumption increases during the 20s and often decreases after age 65 years. Intake is greater in males than in females. With advancing age, people are likely to demonstrate increasingly intense reactions to caffeine, with greater complaints of interference with sleep or feelings of hyperarousal.

Prevalence

The pattern of caffeine use fluctuates during life, with 80%–85% of adults consuming caffeine in any given year. Among people who consume caffeine, 85% or more use a caffeine-containing beverage at least once a week, imbibing an average of almost 200 mg/day. Caffeine intake is probably elevated among individuals who smoke, and perhaps among those who use alcohol and other substances. The prevalence of Caffeine-Related Disorders is unknown.

Course

Caffeine intake usually begins in the mid-teens, with increasing levels of consumption through the 20s into the 30s, when use levels off and perhaps begins to fall. Among the approximately 40% of individuals who have stopped the intake of some form of caffeine, most report that they changed their pattern in response to its side effects or health concerns. The latter include cardiac arrhythmias, other heart problems, high blood pressure, fibrocystic disease of the breast, insomnia, or anxiety. Because tolerance to the behavioral effects of caffeine does occur, Caffeine Intoxication is often seen in those who use caffeine less frequently or in those who have recently increased their caffeine intake by a substantial amount.

Differential Diagnosis

For a general discussion of the differential diagnosis of Substance-Related Disorders, see p. 207. Caffeine-Induced Disorders may be characterized by symptoms (e.g., Panic Attacks) that resemble **primary mental disorders** (e.g., Panic Disorder versus Caffeine-Induced Anxiety Disorder, With Panic Attacks, With Onset During Intoxication). See p. 210 for a discussion of this differential diagnosis.

To meet criteria for Caffeine Intoxication, the symptoms must not be due to a **general medical condition** or **another mental disorder,** such as an **Anxiety Disorder,** that could better explain them. **Manic Episodes, Panic Disorder, Generalized Anxiety Disorder, Amphetamine Intoxication, Sedative, Hypnotic, or Anxiolytic Withdrawal** or **Nicotine Withdrawal, Sleep Disorders,** and **medication-induced side effects** (e.g., akathisia) can cause a clinical picture that is similar to that of Caffeine Intoxication. The temporal relationship of the symptoms to increased caffeine use or to abstinence from caffeine helps to establish the diagnosis. Caffeine Intoxication is differentiated from **Caffeine-Induced Anxiety Disorder, With Onset During Intoxication** (p. 479), and from **Caffeine-Induced Sleep Disorder, With Onset During Intoxication** (p. 655), by the fact that the symptoms in these latter disorders are in excess of those usually associated with Caffeine Intoxication and are severe enough to warrant independent clinical attention.

292.9 Caffeine-Related Disorder Not Otherwise Specified

The Caffeine-Related Disorder Not Otherwise Specified category is for disorders associated with the use of caffeine that are not classifiable as Caffeine Intoxication, Caffeine-Induced Anxiety Disorder, or Caffeine-Induced Sleep Disorder. An example is caffeine withdrawal (see p. 764 for suggested research criteria).

Cannabis-Related Disorders

This section includes problems that are associated with substances that are derived from the cannabis plant (cannabinoids) and chemically similar synthetic compounds.

Diagnostic criteria for 300.3 Obsessive-Compulsive Disorder *(continued)*

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

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309.81 Posttraumatic Stress Disorder

Diagnostic Features

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe

automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase.

The traumatic event can be reexperienced in various ways. Commonly the person has recurrent and intrusive recollections of the event (Criterion B1) or recurrent distressing dreams during which the event can be replayed or otherwise represented (Criterion B2). In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment (Criterion B3). These episodes, often referred to as "flashbacks," are typically brief but can be associated with prolonged distress and heightened arousal. Intense psychological distress (Criterion B4) or physiological reactivity (Criterion B5) often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., anniversaries of the traumatic event; cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for combat veterans of the South Pacific; entering any elevator for a woman who was raped in an elevator).

Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event (Criterion C1) and to avoid activities, situations, or people who arouse recollections of it (Criterion C2). This avoidance of reminders may include amnesia for an important aspect of the traumatic event (Criterion C3). Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. The individual may complain of having markedly diminished interest or participation in previously enjoyed activities (Criterion C4), of feeling detached or estranged from other people (Criterion C5), or of having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality) (Criterion C6). The individual may have a sense of a foreshortened future (e.g., not expecting to have a career, marriage, children, or a normal life span) (Criterion C7).

The individual has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived (Criterion D1), hypervigilance (Criterion D4), and exaggerated startle response (Criterion D5). Some individuals report irritability or outbursts of anger (Criterion D2) or difficulty concentrating or completing tasks (Criterion D3).

Specifiers

The following specifiers may be used to specify onset and duration of the symptoms of Posttraumatic Stress Disorder:

Acute. This specifier should be used when the duration of symptoms is less than 3 months.

Chronic. This specifier should be used when the symptoms last 3 months or longer.

With Delayed Onset. This specifier indicates that at least 6 months have passed between the traumatic event and the onset of the symptoms.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Posttraumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Avoidance patterns may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job. Auditory hallucinations and paranoid ideation can be present in some severe and chronic cases. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.

Posttraumatic Stress Disorder is associated with increased rates of Major Depressive Disorder, Substance-Related Disorders, Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, Specific Phobia, and Bipolar Disorder. These disorders can either precede, follow, or emerge concurrently with the onset of Posttraumatic Stress Disorder.

Associated laboratory findings. Increased arousal may be measured through studies of autonomic functioning (e.g., heart rate, electromyography, sweat gland activity).

Associated physical examination findings and general medical conditions. Physical injuries may occur as a direct consequence of the trauma. In addition, chronic Posttraumatic Stress Disorder may be associated with increased rates of somatic complaints and, possibly, general medical conditions.

Specific Culture and Age Features

Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals.

In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may also be "omen formation"—that is, belief in an ability to foresee future untoward events. Children may also exhibit various physical symptoms, such as stomachaches and headaches.

Prevalence

Community-based studies reveal a lifetime prevalence for Posttraumatic Stress Disorder of approximately 8% of the adult population in the United States. Information is not currently available with regard to the general population prevalence in other countries. Studies of at-risk individuals (i.e., groups exposed to specific traumatic incidents) yield variable findings, with the highest rates (ranging between one-third and more than half of those exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.

Course

Posttraumatic Stress Disorder can occur at any age, including childhood. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear. Frequently, a person's reaction to a trauma initially meets criteria for Acute Stress Disorder (see p. 469) in the immediate aftermath of the trauma. The symptoms of the disorder and the relative predominance of reexperiencing, avoidance, and hyperarousal symptoms may vary over time. Duration of the symptoms varies, with complete recovery occurring within 3 months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma. In some cases, the course is characterized by a waxing and waning of symptoms. Symptom reactivation may occur in response to reminders of the original trauma, life stressors, or new traumatic events.

The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Posttraumatic Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

Familial Pattern

There is evidence of a heritable component to the transmission of Posttraumatic Stress Disorder. Furthermore, a history of depression in first-degree relatives has

been related to an increased vulnerability to developing Posttraumatic Stress Disorder.

Differential Diagnosis

In Posttraumatic Stress Disorder, the stressor must be of an extreme (i.e., life-threatening) nature. In contrast, in **Adjustment Disorder,** the stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situations in which the response to an extreme stressor does not meet the criteria for Posttraumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to Posttraumatic Stress Disorder. **Symptoms of avoidance, numbing, and increased arousal that are present before exposure to the stressor** do not meet criteria for the diagnosis of Posttraumatic Stress Disorder and require consideration of other diagnoses (e.g., a Mood Disorder or another Anxiety Disorder). Moreover, if the symptom response pattern to the extreme stressor meets criteria for **another mental disorder** (e.g., Brief Psychotic Disorder, Conversion Disorder, Major Depressive Disorder), these diagnoses should be given instead of, or in addition to, Posttraumatic Stress Disorder.

Acute Stress Disorder is distinguished from Posttraumatic Stress Disorder because the symptom pattern in Acute Stress Disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist for more than 1 month and meet criteria for Posttraumatic Stress Disorder, the diagnosis is changed from Acute Stress Disorder to Posttraumatic Stress Disorder.

In **Obsessive-Compulsive Disorder,** there are recurrent intrusive thoughts, but these are experienced as inappropriate and are not related to an experienced traumatic event. **Flashbacks** in Posttraumatic Stress Disorder must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in **Schizophrenia, other Psychotic Disorders, Mood Disorder With Psychotic Features, a delirium, Substance-Induced Disorders,** and **Psychotic Disorders Due to a General Medical Condition.**

Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role.

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder *(continued)*

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor